SECTION 5:

ONGOING RESIDENT RECORDS

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INTRODUCTION TO ONGOING RESIDENT RECORDS

SUBMITTED TO THE DEPARTMENT

The following are to be completed and submitted to the regional certifying agent:

Upon a Critical Incident (i.e., any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or wellbeing of a resident):

- ☐ Critical Incident Report
  - Submit within 24 hours of the resident's death or disappearance
  - Submit within three (3) business days of the resident's hospitalization, emergency room or urgent care clinic visit, or contact from adult protective services or law enforcement in conjunction with an investigation

MAINTAINED BY THE PROVIDER

The following are to be completed with updated information at the time services are rendered by the provider on an ongoing basis. Maintain records for five (5) years from the date of service.

- ☐ Incident / Accident / Change in Condition form for any such events involving the resident that do not rise to the level of a critical incident
  - If an incident occurs while the resident is receiving supportive services, obtain a written incident report from the service provider
- ☐ Grievance Response Record when the resident (or resident's representative) voices concern regarding the care or services that are (or fail to be) provided, including issues with other residents
- ☐ If the provider, provider's relative, or other member of the provider's household manages the resident's funds:
  - Bank statements to which use of the resident's funds may be reconciled
  - Resident Cash Ledger, when cash withdrawals are made from the resident's account
  - Receipts for purchases over $5 for which the resident's personal funds were used
    - Maintain the receipt with the corresponding bank statement or cash ledger
- ☐ If the provider, provider's relative, or other member of the provider's household lends the resident money, the Personal Loan Contract
  - Only people who are relatives of the resident may lend the resident money
  - Borrowing money from the resident is prohibited
- ☐ If the provider or other staff in the certified family home assists the resident with medications:
  - Narcotic Inventory, when the resident is prescribed an opioid pain reliever
  - Medication Assistance Record
  - Medication Disposal Record, immediately when a loose pill is discovered, or within 30 days of the following:
    - A medication is discontinued by the resident's health care professional
    - A medication passes its expiration date
- ☐ If applicable, notes from the licensed nurse, home health agency, physical therapist, or any other service provider, documenting the services provided to the resident at each visit to the home

GRIEVANCE RESPONSE RECORD

IDAPA 16.03.19.200.09.a: The resident has the right to voice or file a grievance with respect to care or service that is or fails to be furnished, without discrimination or reprisal for voicing the grievance and the right to prompt efforts by the provider to resolve grievances the resident may have, including those with respect to the behavior of other residents.

IDAPA 16.03.19.200.09.b: The provider must provide a written response to the resident or resident's representative describing how he resolved or attempted to resolve the grievance, and maintain a copy of this written response in the resident record.

Resident Name:	Date of Grievance:
Description of Grievance:	
Date of Response:	
How the Grievance was Resolved or How the Provider Attempted to Resolve the Grievance:	
CFH Provider Signature:	
Resident Signature:	

INCIDENT / ACCIDENT / CHANGE IN CONDITION

Per IDAPA 16.03.19.270.02, the provider must maintain in the resident's record documentation of any incident, accident, or change in condition involving the resident.

Examples

INCIDENT	ACCIDENT (NOT REQUIRING MEDICAL INTERVENTION)	CHANGE IN CONDITION
Adverse Reactions to Medications or Missed Dosages	Minor Cuts, Bruises, etc.	Unusual Disorganized Thoughts or Memory Loss
Refusal to Follow a Restricted Diet	Minor Sprains or Other Injuries	Unusual Disorientation
Destructive or Self-Harming Behavior	Falls in which there is No Apparent or Only Minor Injury	Unusual Incontinence

Complete and submit to the Department a Critical Incident Report if the following apply: elopement, death, hospitalization, visit to an emergency room or urgent care clinic, and/or law enforcement or adult protection investigation. For less serious events, complete the form below and maintain with the resident's records.

Name of Resident:		
DATE AND TIME OF INCIDENT, ACCIDENT, OR CHANGE IN CONDITION	DETAILS	PROVIDER'S RESPONSE

Name of Resident:		
DATE OF INCIDENT, ACCIDENT, OR CHANGE IN CONDITION	DETAILS	PROVIDER'S RESPONSE

CRITICAL INCIDENT REPORT

A critical incident is any actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety or wellbeing of a resident. Certified family home (CFH) providers are required to report critical incidents to their regional certifying agents per IDAPA 16.03.19.210.03.

Send completed forms by email to CFHCC@dhw.idaho.gov or by fax to 208-239-6250.

PROVIDER INFORMATION

The provider is the adult responsible for maintaining the home and providing care to residents.

Full Legal Name:		Certificate No.:
Telephone Number: ( )	Email:	
Physical Address:		
Physical City:	Physical State:	Physical ZIP:

RESIDENT INFORMATION

The resident is the vulnerable adult living in the provider's home and who was involved in the critical incident.

Full Legal Name:	Date of Birth:

REPORTING TIMELINE

Critical incidents have various timeline reporting requirements based on the nature of the incident. Check all that apply.

Twenty-four (24) Hours. If the critical incident can be classified as indicated to the right, the provider is to submit this report to the regional certifying agent within 24 hours.	☐ **Elopement.** The resident left the CFH without notifying the provider as to his or her whereabouts, or the resident did not return from an outing as expected by the provider. ☐ **Death.** The resident passed away.
Three (3) Business Days. If the critical incident can be classified as indicated to the right, the provider is to submit this report to the regional certifying agent within three (3) business days.	☐ **Hospitalization.** The resident was admitted to a hospital due to a change in condition, serious illness, or serious accident. ☐ **Emergency Room or Urgent Care.** The resident visited an emergency room or urgent care clinic due to a change in condition, serious illness, or serious accident. ☐ **Investigation.** The resident is the subject (either as an alleged victim or an alleged perpetrator) of a law enforcement or adult protective services investigation.

DESCRIPTION OF CRITICAL INCIDENT

An account of the critical incident, including events that led to the incident and the provider's response.

Date of Critical Incident:	Time of Critical Incident: _____:_____ A.M. ☐ P.M. ☐
Description of Events:	

Send completed forms by email to CFHCC@dhw.idaho.gov or by fax to 208-239-6250.

RESIDENT CASH LEDGER

Resident Name:	Provider Name:

DATE	CASH WITHDRAWAL*	CASH PURCHASE	DESCRIPTION	BALANCE OF CASH ON-HAND

*Cash Withdrawal is the amount of cash that is withdrawn from the resident's bank account and kept on-hand for the resident's use. There should be a corresponding transaction on the resident's bank statement showing the cash withdrawal.

PERSONAL LOAN CONTRACT

Only a relative of the resident may make a personal loan to the resident when the lender is a certified family home (CFH) provider, a relative of the provider, or a member of the provider's household. When such a loan is made, the CFH provider must ensure the terms of the loan are described in a written contract signed by the resident or resident's representative and maintained in the resident's records. Additionally, the provider must immediately document repayments toward the loan. See IDAPA 16.03.19.275.01.c.

PROVIDER INFORMATION

The provider is the adult responsible for maintaining the CFH and providing care to residents.

Full Legal Name:	Certificate No.:

RESIDENT INFORMATION

The resident is the vulnerable adult living in the provider's CFH who is the recipient of a personal loan.

Full Legal Name:	Date of Birth:

LENDER INFORMATION

The lender is the individual who is making a personal loan to the resident.

Full Legal Name:	Loan Amount:
Telephone Number: ( )	Email Address:
Relationship to Resident:	Relationship to Provider:

TERMS OF THE LOAN

The terms under which the personal loan is to be repaid to the lender.

Date the Loan Amount is to be Repaid in Full to the Lender:	
Other Terms of the Loan:	
_____ RESIDENT'S OR RESIDENT'S REPRESENTATIVE'S SIGNATURE	_____ DATE

REPAYMENT TRACKING

The provider must immediately update documentation of repayments towards the loan.

Payment Date	Payment Amount	Loan Balance

Payment Date	Payment Amount	Loan Balance

Payment Date	Payment Amount	Loan Balance

NARCOTIC INVENTORY

Providers who assist residents with prescribed narcotics are required to document an inventory at least monthly as described in IDAPA 16.03.19.402.05.e. Narcotic medications are opioid pain-relievers (e.g., Oxycodone, Hydrocodone, Morphine, Fentanyl, etc.).

PROVIDER INFORMATION

The provider is the adult operating the certified family home and responsible for management of the resident's medication.

Provider Name:	Certificate No.:

NARCOTIC & INITIAL INVENTORY

Identify the specific narcotic medication that is the subject of inventories recorded on this form and conduct an initial inventory of that medication. Return medications to their original containers after counting the Amount On-hand. Newly prescribed narcotics should be inventoried upon filling the prescription. Newly certified homes should inventory existing narcotics within 30 days of certification.

Medication Name:		Dosage:
Prescribed to Resident:		Amount On-hand:
Provider Signature:	Date:	Time: A.M. ☐ P.M. ☐

ONGOING INVENTORIES

Conduct and document ongoing inventories of the narcotic named above at least every 30 days. The Previous Amount On-hand for the first ongoing inventory below equals the Amount On-hand from the Initial Inventory above; subsequently, the Previous Amount On-hand equals the Amount On-hand from the previous ongoing inventory. Return medications to their original containers after counting the Amount On-hand.

PHYSICAL INVENTORY		RECORDS RECONCILIATION	
Date:	Time: A.M. ☐ P.M. ☐		Previous Amount On-hand:
Provider Signature:		(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY		RECORDS RECONCILIATION	
Date:	Time: A.M. ☐ P.M. ☐		Previous Amount On-hand:
Provider Signature:		(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY		RECORDS RECONCILIATION	
Date:	Time: A.M. ☐ P.M. ☐		Previous Amount On-hand:
Provider Signature:		(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY		RECORDS RECONCILIATION	
Date:	Time: A.M. ☐ P.M. ☐		Previous Amount On-hand:
Provider Signature:		(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY		RECORDS RECONCILIATION	
Date:	Time: A.M. ☐ P.M. ☐		Previous Amount On-hand:
Provider Signature:		(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY		RECORDS RECONCILIATION	
Date:	Time: A.M. ☐ P.M. ☐		Previous Amount On-hand:
Provider Signature:		(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY		RECORDS RECONCILIATION	
Date:	Time: A.M. ☐ P.M. ☐		Previous Amount On-hand:
Provider Signature:		(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY		RECORDS RECONCILIATION	
Date:	Time: A.M. ☐ P.M. ☐		Previous Amount On-hand:
Provider Signature:		(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY		RECORDS RECONCILIATION	
Date:	Time: A.M. ☐ P.M. ☐		Previous Amount On-hand:
Provider Signature:		(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY		RECORDS RECONCILIATION	
Date:	Time: A.M. ☐ P.M. ☐		Previous Amount On-hand:
Provider Signature:		(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY		RECORDS RECONCILIATION	
Date:	Time: A.M. ☐ P.M. ☐		Previous Amount On-hand:
Provider Signature:		(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Records Reconciliation Check:

PHYSICAL INVENTORY		RECORDS RECONCILIATION	
Date:	Time: A.M. ☐ P.M. ☐		Previous Amount On-hand:
Provider Signature:		(plus)	Amount Refilled Since Last Inventory:
Amount On-hand:		(minus)	Amount Given Since Last Inventory:
		(minus)	Amount Destroyed Since Last Inventory:
		(equals)	Records Reconciliation Check:

MEDICATION ASSISTANCE RECORD

Per IDAPA 16.03.19.400.01-02, the certified family home provider must only assist the resident with medications that are ordered by the resident's health care professional as indicated by written evidence of the order. This includes prescription and over-the-counter medications, supplements, and home remedies. Document assistance with medications below. For PRN medications, use the backside of this form. In addition to indicating an omission or refusal below, document missed dosages of prescription medications as incidents, including why the dose was missed and the provider's response on a separate incident report.

Resident Name:	Provider Name:	Month:	Year:
Resident's Known Allergies:			

Medication, Dosage & Route	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	A.M.																															
	Midday																															
	P.M.																															
	Eve																															
	A.M.																															
	Midday																															
	P.M.																															
	Eve																															
	A.M.																															
	Midday																															
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	Eve																															
	A.M.																															
	Midday																															
	P.M.																															
	Eve																															

PRN MEDICATIONS

Per IDAPA 16.03.19.402.07.c., documentation indicating the reason for assisting the resident with any PRN medication, including both over-the-counter and prescription PRN medications, must be maintained by the provider. Document assistance with PRN medications below.

Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	
Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	
Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	
Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	
Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	
Medication:	Dosage:	Route:	Date:	Time: AM or PM
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Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	
Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	
Medication:	Dosage:	Route:	Date:	Time: AM or PM
Reason Given:	Result:		Signature:	

MEDICATION DISPOSAL RECORD

Medications that are expired or discontinued by the resident's health care professional must be disposed of by the CFH provider within thirty (30) calendar days.

RESIDENT INFORMATION

The resident is the vulnerable adult living in the provider's CFH whose medication is being disposed.

Full Legal Name:	Date of Birth:

DISPOSAL INFORMATION

Medication Name:	Dosage:
Amount Disposed:	
Reason for Disposal: ☐ The medication was discontinued by the resident's health care professional. ☐ The medication had passed its expiration date. ☐ Other (please describe): _____	
Method of Disposal:	
Provider Signature:	Date of Disposal:
Adult Witness Signature: *(must not be a resident):*	Date:

Medication Name:	Dosage:
Amount Disposed:	
Reason for Disposal: ☐ The medication was discontinued by the resident's health care professional. ☐ The medication had passed its expiration date. ☐ Other (please describe): _____	
Method of Disposal:	
Provider Signature:	Date of Disposal:
Adult Witness Signature *(must not be a resident):*	Date:

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